CENTRAL MONTANA REGIONAL TRAUMA ADVISORY COMMITTEE
A Consortium of Health Care Facilities
Dedicated to the Care of the Trauma Patient

CENTRAL REGIONAL TRAUMA ADVISORY COMMITTEE MEETING MINUTES
October 27, 2005
Benefis Healthcare, Great Falls, MT.

PRESENT: Michael B. Orcutt, MD, CRTAC Chairman, Great Falls
Pete Lucas, RN, CRTAC Secretary, Great Falls

Audrey Rouns, EMT, Conrad	Myron Frydenlund, EMT, Shelby
Riki Handstede, RN, Havre	Scott Schandelson, RN, Great Falls
Jeff Chelmo, PA-C, Chester	Jennie Wicks, RN, Chester
Crissa Oliva, Rocky Boy	Carol Kussman, RN, Helena
Beverly and James Zehntner, WSS	Rosie Rosalez, EMT-P, Great Falls

GUESTS: Jennie Nemec, RN, Department of Public Health and Human Services
ABSENT: **Representatives from:**

Cutbank	**Fort Belknap**
Browning	**Townsend**
Big Sandy	**Conrad**
Choteau	

Secretary, Pete Lucas, RN at 1215 p.m., called the Central Montana Rural Trauma Advisory Committee (CRTAC) to order. Benefis Healthcare hosted a lunch prior to the meeting. Roll call was taken. Introductions were made. The minutes of the last meeting were re-capped and approved.

STATE TRAUMA CARE COMMITTEE ACTIVITIES: The next STCC meeting will be on November 14, 2005 at the Wingate Inn in Helena. An agenda of the meeting will soon be coming. The CRTAC needs to provide 2 names to the STCC who are interested in sitting on the committee. Possible candidates need to supply a letter of intent and a Curriculum Vitae. The trauma system rules are ready for submission to public hearings on November 8, 2005 and the process will take approximately two weeks. The rules will then be placed into effect.
ATLS courses will be held on November 4-5, 2005 in Billings @ St. Vincent's. Another course will be on December 9-10 in Billings @ Deaconess Billings Clinic. Audit slots are available for RN's who would like to attend. The participant would not be eligible for testing on either the written or skill stations. Interested individuals are to contact Pete Lucas for possible deferment of the registration cost through the RTAC grant.
Thom Danenhower has resigned his position as the Injury Prevention Program Coordinator. The position is vacant at this time.
A new position, named the EMS System Manager, has been created and is open at this time.
The EMS rules will soon be completed and be able to be distributed.
CRTAC SUBCOMMITTEES:

1. **Injury Prevention and Public Education:** Pete shared with the committee that TNCC courses continue to be held in Great Falls, as well as ENPC courses. The "TEAM" presentation is also available and facilities are

encouraged to participate in this education and sharing of information. The STN (Society of Trauma Nursing) course has been conducted in some facilities and is available for others as well. The course is very similar to TNCC and is a two-day course.

2. **Pre-Hospital:** Rosie shared with the committee that the pre-hospital sub-committee did not meet prior to this RTAC and are planning on another meeting to take place prior to the next RTAC in January 2006. A PHTLS course is scheduled for Choteau and thus far fourteen participants are signed up. Fort Benton is still interested in hosting a course in the future. Please contact Rosie if interested in PHTLS.
3. **Regional Trauma Plan:** No report available at this time.
4. **Quality Improvement:** No cases were identified for review this meeting. Facilities within the CRTAC please provide cases for review. The reviews are completed in a non-threatening environment as an educational process only. This has generated very positive discussion and feedback in the past.

STATE TRAUMA REPORT: Given in the STCC portion of the agenda.

STATE INJURY PREVENTION REPORT: No report available at this time.
CRTAC EDUCATION GRANT FROM THE GENERAL FUND: Pete informed the committee that there was over $12,000.00 in the account available for education. Some suggestions on the use of the money included: 1. Develop a one-day trauma symposium for the CRTAC, and possibly make it portable to rotate sites. 2. Look into securing the STARS mannequin from Canada for an educational day. Both excellent ideas and would benefit all in the central region.

A tentative talk by Dr. Stu Reynolds will be given in January 2006 on Bioterrism.

The meeting was adjourned at 1345 after roundtable.

Dates for FY 2006 have been chosen and will be held in Great Falls unless otherwise specified:
January 26, 2006
April 27, 2006
July 27, 2006
October 26, 2006
Start time will be @ 1230.

Respectfully submitted,

Pete Lucas, RN, TNC
Secretary, Central RTAC
(406) 455-4422, lucapetn@benefis.org

TRAUMA FACILITY RESOURCE CRITERIA

Montana Department of Public Health and Human Services
EMS and Trauma Systems Section

Note: Occasional variances from these standards may occur. These should be reviewed as part of the hospital's performance/performance improvement process.

The following table shows levels of categorization and their essential "E" or desirable "D" characteristics

	LEVELS			
	Regional Trauma Center	**Area Trauma Hospital**	**Community Trauma Hospital**	**Trauma Receiving Facility**
FACILITY ORGANIZATION				
Facility				
Demonstrated institutional commitment / resolution by the hospital Board of Directors and Medical Staff to maintain the human and physical resources to optimize trauma patient care provided at the facility.	E	E	E	E
Participation in the statewide trauma system including participation in Regional Trauma Advisory Committee; support of regional and state performance improvement programs; and submission of data to the Montana State Trauma Registry.	E	E	E	E
Trauma Service				
A clinical service recognized in the medical staff structure that has the responsibility for the oversight of the care of the trauma patient. Specific delineation or credentialing of privileges for the medical staff on the Trauma Service must occur.	E	D		
Trauma Program				
Multidisciplinary program that coordinates trauma-related activities including performance/performance improvement for trauma patients, educational programs for providers of trauma care, injury prevention, and public education.	E	E	E	E
Trauma Team				
A team of care providers to provide initial evaluation, resuscitation and treatment for all trauma patients meeting trauma system triage criteria. The members of the team must be identified and have written roles and responsibilities.	E	E	E	E
The trauma team is organized and directed by a general surgeon with demonstrated competence in trauma care who assumes responsibility for coordination of overall care of the trauma patient.	E	E	E1	
The trauma team is organized and directed by a physician, Physician Assistant, or Nurse Practitioner with demonstrated competency in trauma care and is responsible for the overall provision of care for the trauma patient from resuscitation through discharge.				E
A method and written trauma system triage criteria to activate the trauma team must exist.	E	E	E	E

	LEVELS			
	Regional Trauma Center	Area Trauma Hospital	Community Trauma Hospital	Trauma Receiving Facility
Trauma Medical Director				
Board-certified or board eligible surgeon (usually general surgery) with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director should have the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, recommending trauma service privileges, development of treatment protocols, coordinating performance/performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.	E			
Physician board-certified or board eligible in Surgery or Emergency Medicine with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director should have the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, recommending trauma service privileges, development of treatment protocols, coordinating performance/performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.		E		
Physician board-certified in Surgery, Emergency Medicine, Family Practice, Internal Medicine or OB/GYN; with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director should have the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, development of treatment protocols, coordinating performance/performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.			E	
Physician, Nurse Practitioner, or Physician Assistant with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director should have the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, development of treatment protocols, coordinating performance/performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.				E
Completion of an ATLS course with preference for current verification or being an ATLS instructor.	E	E	E	D
Trauma Coordinator				
A full-time dedicated registered nurse working in concert with the trauma director, with responsibility for organization of services and systems necessary for a multidisciplinary approach to care for the injured. Activities include clinical oversight, trauma education and prevention, performance/performance improvement, supervision of the trauma registry, administration, consultation/liaison and involvement in community, regional and the state trauma system.	E			

	LEVELS			
	Regional Trauma Center	Area Trauma Hospital	Community Trauma Hospital	Trauma Receiving Facility
A registered nurse working in concert with the trauma director, with responsibility for organization of services and systems necessary for a multidisciplinary approach to care for the injured. Activities include clinical care and oversight, trauma education and prevention, performance/performance improvement, trauma registry, and involvement in community and regional trauma system. There must be dedicated hours for this position.		E	E	E
Trauma Committee				
Trauma Program Performance function is performed with a multidisciplinary committee of all trauma related services to assess and correct global trauma program process issues. This committee meets regularly, takes attendance, has minutes, and works to correct overall program deficiencies to optimize trauma patient care.	E	E	E	E
Trauma Peer Review function is performed with a multidisciplinary committee of care providers to perform peer review for issues such as response times, appropriateness and timeliness of care, and evaluation of care priorities. This committee under the aegis of performance/performance improvement meets regularly, takes attendance, has minutes, and documents how patient care problems will be avoided in the future (loop closure).	E	E	E	E
Diversion Policy				
A written policy and procedure to divert patients to another designated trauma care service when the facility's resources are temporarily unavailable for optimal trauma patient care.	E	E	E	D
Interfacility Transfer				
Interfacility transfer guidelines and agreements consistent with the scope of the trauma service practice available at the facility.	E	E	E	E
Disaster Preparedness				
A written disaster plan that is updated routinely.	E	E	E	E
The facility participates in community disaster drills.	E	E	E	E
FACILITY DEPARTMENTS / DIVISIONS / SECTIONS				
Surgery	E	E	E	
Neurosurgical Surgery	E	D		
Neurosurgical Trauma Liaison	E	D		
Orthopedic Surgery	E	D	D	
Orthopedic Trauma Liaison	E	D	D	
Emergency Medicine	E	D	D	
Emergency Medicine Trauma Liaison	E	E	D	
Anesthesia	E	D	D	
CLINICAL CAPABILITIES				
Published on-call schedule	E	E	E	D
General surgery	E	E	E	
Published back-up schedule	E	D		
Dedicated to single hospital when on call	E	D		
Anesthesia	E	E	E	

	LEVELS			
	Regional Trauma Center	Area Trauma Hospital	Community Trauma Hospital	Trauma Receiving Facility
Emergency Department coverage by in-house emergency physician.	E	E		
Emergency Department coverage by in-house physician, Physician Assistant, or Nurse Practitioner			D	
Emergency Department coverage may be physician, Physician Assistant, or Nurse Practitioner on-call and promptly available.			E2	E2
On-call and Promptly Available (within 30 minutes of call)				
General / Trauma Surgeon	E3	E4	E4	
Anesthesiology – MD or CRNA	E5	E5	E	
Cardiac surgery	D			
Critical care medicine	E	D	D	
Hand surgery	E	D		
Microvascular/replant surgery	D			
Neurologic surgery	E	D		
Dedicated to one hospital or backup call	E	D		
Obstetric / Gynecologic surgery	E	D	D	
Ophthalmic surgery	E	D		
Oral / maxillofacial surgery	E	D		
Orthopaedic surgery	E	D	D	
Plastic surgery	E	D		
Pediatrics	E	D		
Radiology	E	E	D	D
Thoracic surgery	E			
Urologic surgery	E	D		
Vascular surgery	E			
CLINICAL QUALIFICATIONS				
General / Trauma Surgeon				
Full, unrestricted general surgery privileges	E	E	E	
Board-certified or board eligible	E	E	D	
ATLS course completion	E	E	E	
Trauma Education: 10 hours of trauma-related CME annually.	E6	E6, 7	D6, 7	
Attendance of the general surgeons at a minimum of 50% multidisciplinary peer review committee meetings.	E	E	D	
Plan in place to notify transferring facilities that the surgeon is not available to the community			E	
Emergency Medicine				
Emergency Medicine board-certified or board eligible	E	D	D	
Emergency Department covered by physicians qualified to care for patients with traumatic injuries who can initiate resuscitative measures.		E	E	D
ATLS course completion	E	E	E	E
Trauma education for physicians, Physician Assistant, or Nurse Practitioner providing Emergency Department coverage: 10 hours of trauma-related CME annually.	E6	E6, 7	E6, 7	D6, 7

	LEVELS			
	Regional Trauma Center	**Area Trauma Hospital**	**Community Trauma Hospital**	**Trauma Receiving Facility**
Attendance of an emergency physician representative at a minimum of 50% multidisciplinary peer review committee meetings	E	E	E	D
Neurologic Surgery				
Board-certified or board-eligible	E	D		
ATLS course completion	D	D		
Trauma Education: 10 hours of trauma-related CME annually.	E6	D6, 7		
Attendance of a neurosurgery representative at a minimum of 50% multidisciplinary peer review committee meetings.	E	E		
Orthopedic Surgery				
Board certified or board eligible	E	D		
ATLS course completion	D	D	D	
Trauma Education: 10 hours of trauma-related CME annually.	E6	D6, 7	D6, 7	
Attendance of an orthopedic surgery representative at a minimum of 50% multidisciplinary peer review committee meetings.	E	E	D	
FACILITIES / RESOURCES / CAPABILITIES				
Emergency Department				
Personnel:				
Designated physician director	E	E	E	D
Emergency Department staffing shall ensure immediate care of the trauma patient	E	E	E	D
Trauma nursing education: 8 hours of trauma-related education annually	E	D	D	D
Nursing personnel who provide continual monitoring of the trauma patient from hospital arrival to disposition to ICU, OR, floor or transfer to another facility	E	E	E	E
***Equipment for resuscitation for patients of* ALL AGES**				
Airway control and ventilation equipment including laryngoscope and endotracheal tubes, bag-mask resuscitator and oxygen source	E	E	E	E
Pulse oximetry	E	E	E	D
Suction devices	E	E	E	E
Qualitative end-tidal CO2 determination	E	E	E	D
Electrocardiograph, oscilloscope, defibrillator	E	E	E	D
Internal paddles	E	E		
CVP monitoring equipment	E	E	D	
Standard IV fluids and administration sets	E	E	E	E
Large bore intravenous catheters	E	E	E	E
Sterile surgical sets for:				
Airway control/cricothyrotomy	E	E	E	E
Thoracostomy (chest tube insertion)	E	E	E	E
Venous cutdown	E	E	D	
Central line insertion	E	E	D	
Thoracotomy	E	E		
Peritoneal lavage	E	E	D	
Arterial Catheters	E	D	D	
Ultrasound	D	D	D	
Drugs necessary for emergency care	E	E	E	E
Cervical traction devices	E	E	D	D

	LEVELS			
	Regional Trauma Center	Area Trauma Hospital	Community Trauma Hospital	Trauma Receiving Facility
Broselow Tape	E	E	E	E
Thermal control equipment:				
Blood and fluids	E	E	D	D
Patient	E	E	E	E
Rapid infuser system	E	E	D	
Communication with EMS vehicles	E	E	E	E
Operating Room				
Personnel				
Adequately staffed and available in a timely fashion 24 hours / day	E8	E8	D	
Age-specific Equipment				
Cardiopulmonary bypass	D			
Operating microscope	D	D		
Thermal control equipment:				
Blood and fluids	E	E	E	
Patient	E	E	E	
X-ray capability, including c-arm image intensifier	E	E	E	
Endoscopes, bronchoscopes	E	E	D	
Craniotomy instruments	E	D		
Equipment for long bone and pelvic fixation	E	E	D	
Rapid infuser system	E	E	D	
Postanesthetic Recovery Room *(ICU is acceptable)*				
Registered nurses available 24 hours / day	E	E	D	
Equipment for monitoring and resuscitation	E	E	E	
Intracranial pressure monitoring equipment	E			
Pulse oximetry	E	E	E	
Thermal control	E	E	E	
Intensive or Critical Care Unit for Injured Patients				
Registered nurses with 8 hours trauma education annually	E	D	D	
Designated surgical director or surgical co-director	E	E		
ICU service physician in-house 24 hours / day	D	D		
Equipment for monitoring and resuscitation	E	E		
Intracranial monitoring equipment	E			
Pulmonary artery monitoring equipment	E	E		
Respiratory Therapy Services				
Available in-house 24 hours / day	E	D	D	
On-call 24 hours / day		E	E	
Radiological Services (Available 24 hours / day)				
In-house radiology technologist	E	D	D	
Radiology technologist available on-call 24 hours / day		E	E	
Angiography	E	D		
Sonography	E	E	D	
Computed Tomography	E	E	D	
In-house CT technician	D			
Magnetic Resonance Imaging	D	D		

	LEVELS			
	Regional Trauma Center	Area Trauma Hospital	Community Trauma Hospital	Trauma Receiving Facility
Clinical Laboratory Service (Available 24 hours / day)				
Standard analysis of blood, urine, and other body fluids, including microsampling when appropriate	E	E	E	D
Blood typing and cross-matching	E	E	E	
Coagulation Studies	E	E	E	
Comprehensive blood bank or access to a community central blood bank and adequate storage facilities	E	E	E	
Massive Transfusion Policy (clinical and laboratory)	E	E	E	
Blood gases and pH determinations	E	E	E	
Microbiology	E	E	E	
Acute Hemodialysis				
In-house or transfer agreement	E	E	E	D
Burn Care – Organized				
In-house or transfer agreement with Burn Center	E	E	E	D
Acute Spinal Cord Management				
In-house or transfer agreement with Regional Acute Spinal Cord Injury Rehabilitation Center	E	E	E	D
Rehabilitation Services				
Transfer agreement to an approved inpatient rehabilitation facility	E	E	E	
Physical Therapy	E	E	D	D
Occupational Therapy	E	D	D	
Speech Therapy	E	D	D	
Social Services	E	E	D	D
PERFORMANCE IMPROVEMENT				
Performance improvement program for trauma patients.	E	E	E	E
Participation in the state Trauma Registry	E	E	E	E
Audit of all trauma deaths	E	E	E	E
Medical staff peer review	E	E	E	D
Medical nursing audit	E	E	E	E
Review of prehospital trauma care	E	E	E	E
Annual trauma conference - multidisciplinary	E	E	D	D
CONTINUING EDUCATION / OUTREACH				
Trauma education provided by hospital for:				
Physician,	E	D	D	
Nurses	E	E	D	
Allied health personnel	E	E	D	
Prehospital personnel provision / participation	E	E	D	
PREVENTION				
Designated prevention coordinator – spokesperson for injury control	E	D		
Outreach activities	E	D	D	
Monitor progress / effect of prevention program	D	D	D	
Information resources for public	E	D	D	D
Collaboration with existing national, regional and state programs	E	D	D	D
Coordination and / or participation in community prevention activities	E	E	D	D
Collaboration with other institutions	D	D	D	D

1 The community trauma hospital must have a trauma team plan for when the general surgeon is available and a second schema for when the general surgeon is not available.

2 A system must be developed to assure early notification of the on-call physician, Physician Assistant, or Nurse Practitioner so that he/she can be present at the time of trauma patient arrival in the Emergency Department. The facility's trauma performance improvement process must document and monitor the response times. The Department, through site surveys, will monitor this performance category.

3 The general surgeon is expected to be present in the ED upon patient arrival in all patients meeting the hospital specific guidelines for defining a major resuscitation when given sufficient advance notification from the field OR within twenty minutes of trauma team activation when the advance notification is short. The Department, through site surveys, will monitor this performance category.

4 Each designated facility will develop processes to assure that the general surgeon on-call for trauma will be notified in a timely manner of an impending trauma patient arrival and that the surgeon will be present to direct the trauma team through the initial resuscitation. The facility's trauma performance improvement process will monitor each surgeon's response times and document these times on the trauma flow sheet. The Department, through site surveys, will monitor this performance category.

5 Local criteria must be established for Anesthesiologists or CRNA to be rapidly available for airway emergencies and operative management. The availability of the Anesthesiologist or CRNA and the absence of delays in airway control and/or operative anesthesia management must be documented in the hospital performance/performance improvement process. The Department, through site surveys, will monitor this performance category.

6 Over a three-year period, 1/3 of the continuing medical education to be should be obtained outside of the physician's own institution and/or by educators from outside the institution.

7 Maintenance of current ATLS verification may replace the trauma related CME requirement.

8 Each designated facility will develop performance improvement processes to assure the operating room is available and on-call operating room staff are notified and respond in a timely manner for emergent surgical procedures.

Trauma Service Statistics Summary Report

Report generated on 10/27/2005
ED Admission Dates from 01/01/2005 to 06/30/2005
Query is CENTRAL_HOSP
Number of Records 91

AGE

	Minor	Major	Fatal	Ins	
000-009	1	1	1	2	5(5%)
010-019	3	9	2	7	21(23%)
020-029	2	4	0	4	10(11%)
030-039	3	3	0	1	7(8%)
040-049	4	5	2	2	13(14%)
050-059	2	8	1	2	13(14%)
060-069	1	6	0	5	12(13%)
070-079	0	3	0	0	3(3%)
080-089	1	3	0	1	5(5%)
090-099	0	0	0	2	2(2%)
100 and Over	0	0	0	0	0(0%)
Unknown	0	0	0	0	0(0%)
Not Specified	0	0	0	0	0(0%)
Sub Total	17	42	6	26	91(100%)

GENDER

	Minor	Major	Fatal	Ins	
Male	16	26	5	19	66(73%)
Female	1	16	1	7	25(27%)
Unknown	0	0	0	0	0(0%)
Not Specified	0	0	0	0	0(0%)
Sub Total	17	42	6	26	91(100%)

RACE

	Minor	Major	Fatal	Ins	
White	15	35	4	21	75(82%)
Black	0	1	0	0	1(1%)
Hispanic	0	0	0	1	1(1%)
American Indian	0	3	2	0	5(5%)
Asian	0	1	0	0	1(1%)
Other	0	1	0	0	1(1%)
Invalid	0	0	0	0	0(0%)
Unknown	2	1	0	4	7(8%)
Not Specified	0	0	0	0	0(0%)
Sub Total	17	42	6	26	91(100%)

SYSTEM ACCESS

	Minor	Major	Fatal	Ins	
Prospective					
Dead on Scene	0	0	0	0	0(0%)
Prehospital Care	9	24	6	25	64(70%)
Inter-Facility Transfer	0	10	0	0	10(11%)
Concurrent					
Emergency Department	8	7	0	1	16(18%)
Intra-Facility Transfer	0	0	0	0	0(0%)
Retrospective					
Retrospective Review	0	1	0	0	1(1%)
Other					
Not Applicable	0	0	0	0	0(0%)
Blank	0	0	0	0	0(0%)
Unknown	0	0	0	0	0(0%)
Sub Total	17	42	6	26	91(100%)

MECHANISM TYPE

	Minor	Major	Fatal	Ins	
Blunt	17	36	5	23	81(89%)
Penetrating	0	6	0	2	8(9%)
Burn	0	0	0	1	1(1%)
Anoxic	0	0	1	0	1(1%)
Unknown	0	0	0	0	0(0%)
Not Applicable	0	0	0	0	0(0%)
Blank	0	0	0	0	0(0%)
Sub Total	17	42	6	26	91(100%)

ARRIVAL TIME

	Sun	Mon	Tue	Wed	Thu	Fri	Sat	N/V	
0000-0559	1	1	1	3	2	2	2	0	12(13%)
0600-1159	3	1	1	0	9	4	0	0	18(20%)
1200-1759	5	3	4	7	2	6	5	0	32(35%)
1800-2359	6	1	2	5	3	4	6	0	27(30%)
Not Valued	1	1	0	0	0	0	0	0	2(2%)
Totals	16	7	8	15	16	16	13	0	91(100%)

EMERGENCY DEPARTMENT RESPONSE

Non-Trauma Team		4(4%)
Readmission	0(0%)	
Non-Trauma Service	2(2%)	
Direct Admit	2(2%)	
Trauma Team		86(95%)
Trauma Consult	40(44%)	
Trauma Team Act - Partial	40(44%)	
Trauma Team Act - Full	6(7%)	
Other		1(1%)
Invalid	0(0%)	
Unknown	1(1%)	
Not Applicable	0(0%)	
Blank	0(0%)	
Total		**91**

EMERGENCY DEPARTMENT MINUTES

	< 120	120-239	>239	N/V	Avg.
Discharged					**143**
Home	12(35%)	2(6%)	4(25%)	1(17%)	143
Admitted					**214**
ICU	1(3%)	4(11%)	2(12%)	1(17%)	194
Step Down	0(0%)	0(0%)	0(0%)	0(0%)	-
Floor	2(6%)	12(34%)	6(38%)	1(17%)	224
Pediatrics	0(0%)	0(0%)	2(12%)	0(0%)	250
PICU	0(0%)	0(0%)	0(0%)	0(0%)	-
OR	4(12%)	5(14%)	0(0%)	0(0%)	115
Admitted to Monitored Telemetry Floor Bed	0(0%)	0(0%)	0(0%)	0(0%)	-
Admitted for 23 hour observation	0(0%)	0(0%)	1(6%)	0(0%)	963
Transferred					**122**
Acute Care Hospital	11(32%)	11(31%)	1(6%)	1(17%)	122
Expired (Including DOA)					**35**
Morgue	3(9%)	1(3%)	0(0%)	2(33%)	35
Other					**0**
Other	1(3%)	0(0%)	0(0%)	0(0%)	0
Invalid	0(0%)	0(0%)	0(0%)	0(0%)	-
Unknown	0(0%)	0(0%)	0(0%)	0(0%)	-
Not Applicable	0(0%)	0(0%)	0(0%)	0(0%)	-
Blank	0(0%)	0(0%)	0(0%)	0(0%)	-
Sub Total	34(100%)	35(100%)	16(100%)	6(100%)	163

EMERGENCY DEPARTMENT DISPOSITION

Discharged		19(21%)
Home	**19(21%)**	
Admitted		41(45%)
ICU	8(9%)	
Step Down	0(0%)	
Floor	21(23%)	
Pediatrics	2(2%)	
PICU	0(0%)	
OR	9(10%)	
Admitted to Monitored Telemetry Floor Bed	0(0%)	
Admitted for 23 hour observation	1(1%)	
Transferred		24(26%)
Acute Care Hospital	24(26%)	
Expired (Including DOA)		6(7%)
Morgue	6(7%)	
Other		1(1%)
Other	1(1%)	
Invalid	0(0%)	
Unknown	0(0%)	
Not Applicable	0(0%)	
Blank	0(0%)	
Total		**91**

ICU LENGTH OF STAY

Intensive Care[60 / 9 Patients Average Days= 7]

Admitted (LOS valued)			9(10%)
0-7 Days		7(78%)	
<1	0(0%)		
1	5(71%)		
2	1(14%)		
3	0(0%)		
4	1(14%)		
5	0(0%)		
6	0(0%)		
7	0(0%)		
8-14 Days		0(0%)	
8-9	0(- %)		
10-11	0(- %)		
12-14	0(- %)		
15-21 Days		0(0%)	
22-28 Days		2(22%)	
>28 Days		0(0%)	
Admitted (LOS not valued)			0(0%)

Not Admitted			16(18%)
Not Specified			66(73%)
Total			**91**

HOSPITAL LENGTH OF STAY

Hospital Stay[190 / 41 Patients Average Days= 5]

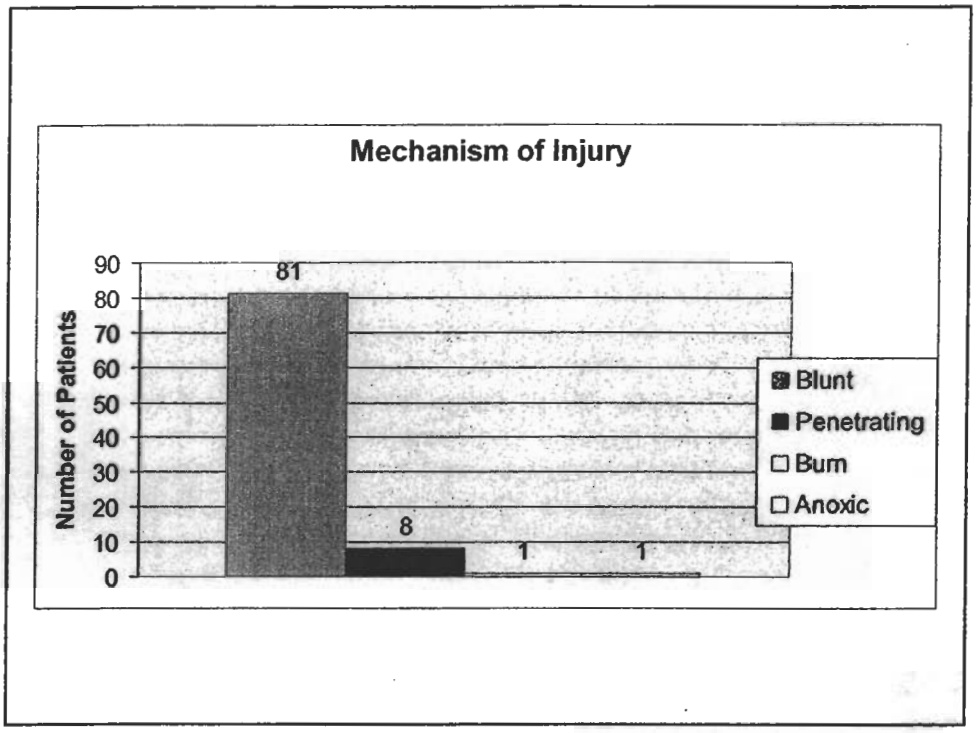
Admitted (LOS valued)			41(45%)
0-7 Days		38(93%)	
<1	0(0%)		
1	11(29%)		
2	8(21%)		
3	2(5%)		
4	8(21%)		
5	4(11%)		
6	4(11%)		
7	1(3%)		
8-14 Days		1(2%)	
8-9	0(0%)		
10-11	1(100%)		
12-14	0(0%)		
15-21 Days		0(0%)	
22-28 Days		0(0%)	
>28 Days		2(5%)	
Admitted (LOS not valued)			0(0%)
Not Admitted			50(55%)
Not Specified			0(0%)
Total			**91**

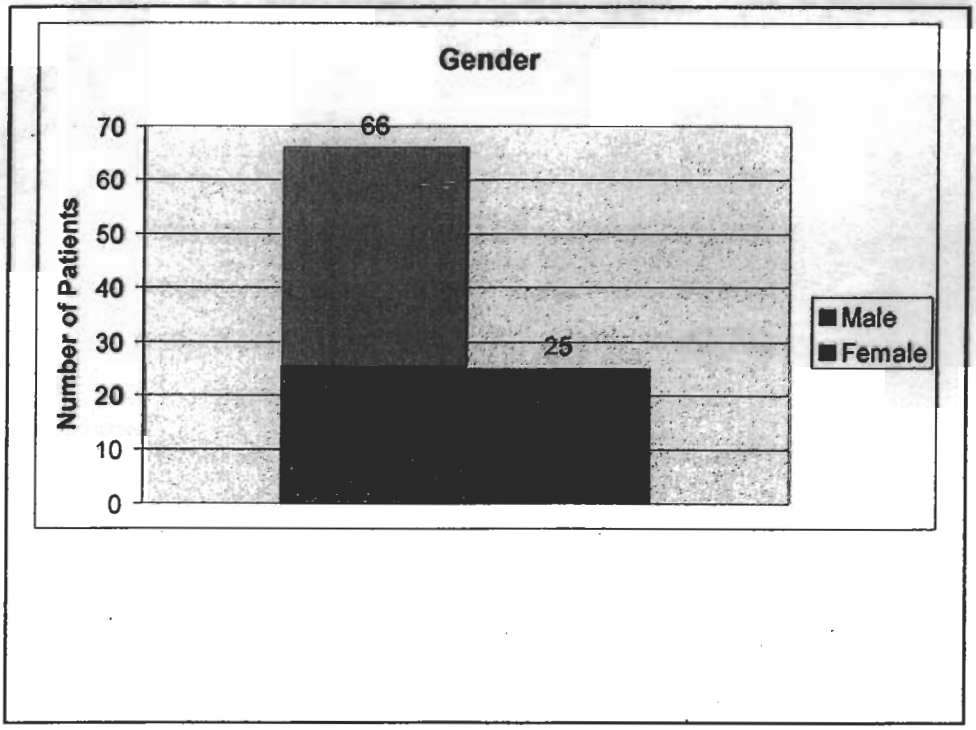
ORGANS DONATED

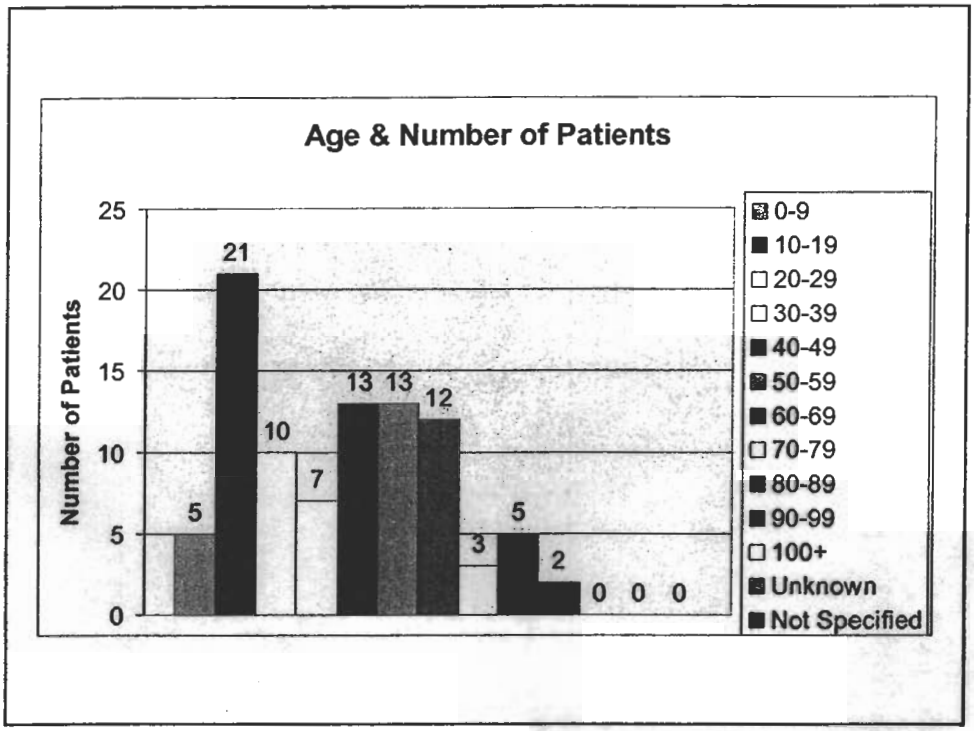
Organs Donated		1(1%)
All / Multiple NFS	1(100%)	
Adrenal Glands	0(0%)	
Bone	0(0%)	
Bone Marrow	0(0%)	
Cartilage	0(0%)	
Cornea	0(0%)	
Dura Mater	0(0%)	
Fascialata	0(0%)	
Heart	0(0%)	
Heart & Lungs	0(0%)	
Heart & Valves	0(0%)	
Kidneys	0(0%)	
Liver	0(0%)	
Lungs	0(0%)	
Nerves	0(0%)	
Pancreas	0(0%)	
Skin	0(0%)	
Tendons	0(0%)	
Invalid	0(0%)	
Unknown	0(0%)	
Total	1(100%)	

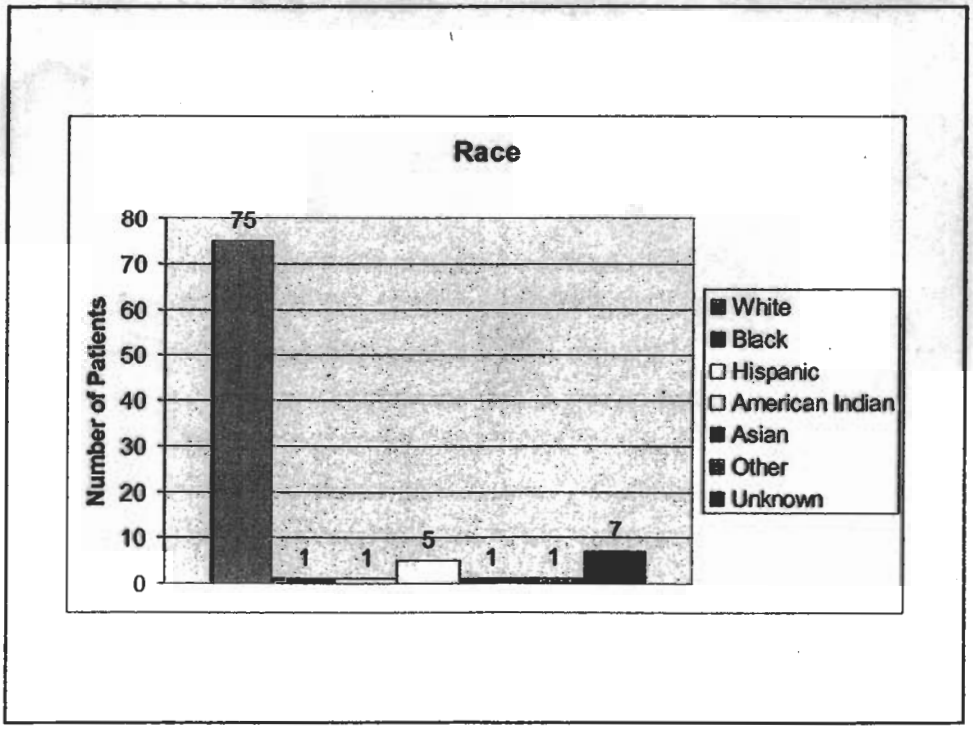
Not Asked		0(0%)
None		1(1%)
Not Applicable		0(0%)
Not Specified		89(98%)
Total		**91**

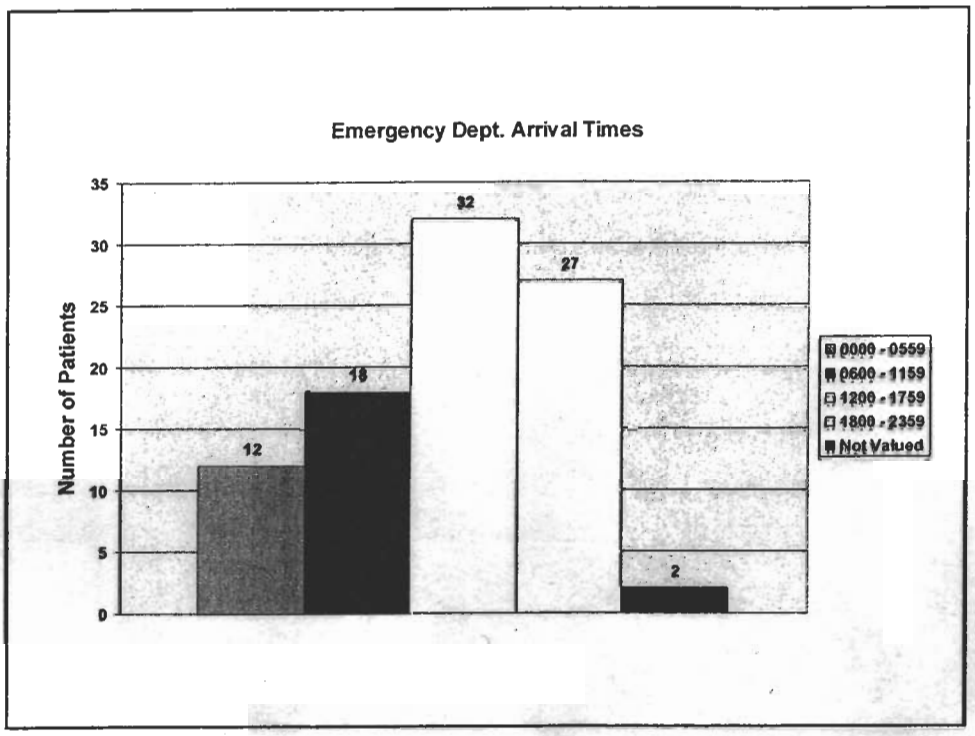
Facility Name	City	# of Patients
Benefis Health Care	Great Falls	20
Liberty County Hospital	Chester	7
Missouri River Medical Center	Fort Benton	15
Mountainview Medical Center	White Sulphr Sprgs	4
Northern Montana Hospital	Havre	1
PHS Indian Hospital	Browning	2
St. Peter's Hospital	Helena	35
Teton Medical Center	Choteau	6

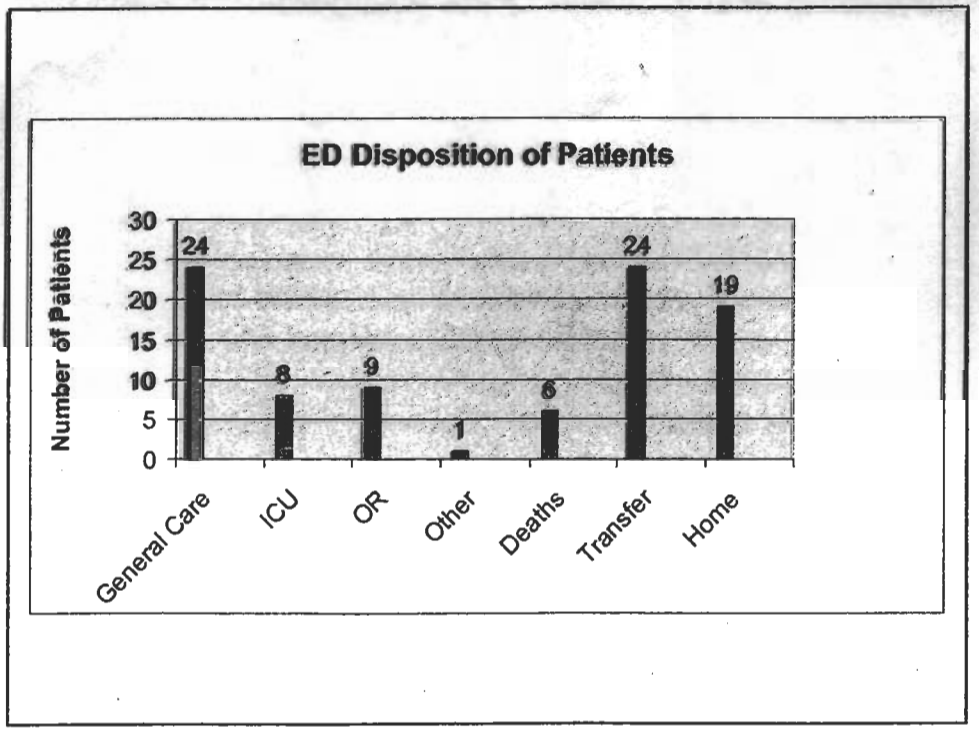

Mechanism of Injury
Number of Patients
90
80
70
60
50
40
30
20
10
0
81
8
1
1
Blunt
Penetrating
Burn
Anoxic


Gender
Number of Patients
70
60
50
40
30
20
10
0
66
25
Male
Female


Age & Number of Patients
Number of Patients
25
20
15
10
5
0
5
21
10
7
13
13
12
3
5
2
0
0
0
0-9
10-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90-99
100+
Unknown
Not Specified


Race
Number of Patients
80
70
60
50
40
30
20
10
0
75
1
1
5
1
1
7
White
Black
Hispanic
American Indian
Asian
Other
Unknown


Emergency Dept. Arrival Times
Number of Patients
35
30
25
20
15
10
5
0
12
18
32
27
2
0000 - 0559
0600 - 1159
1200 - 1759
1800 - 2359
Not Valued


ED Disposition of Patients
Number of Patients
30
25
20
15
10
5
0
24
8
9
1
6
24
19
General Care
ICU
OR
Other
Deaths
Transfer
Home